OFFICE OF THE INSPECTOR GENERAL FOR MENTAL HEALTH, MENTAL RETARDATION AND SUBSTANCE ABUSE SERVICES

Eastern State Hospital
Williamsburg, Virginia

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Inspector General

OIG Report #115-05

EASTERN STATE HOSPITAL
WILLIAMSBURG, VIRGINIA
March 8-11, 2005
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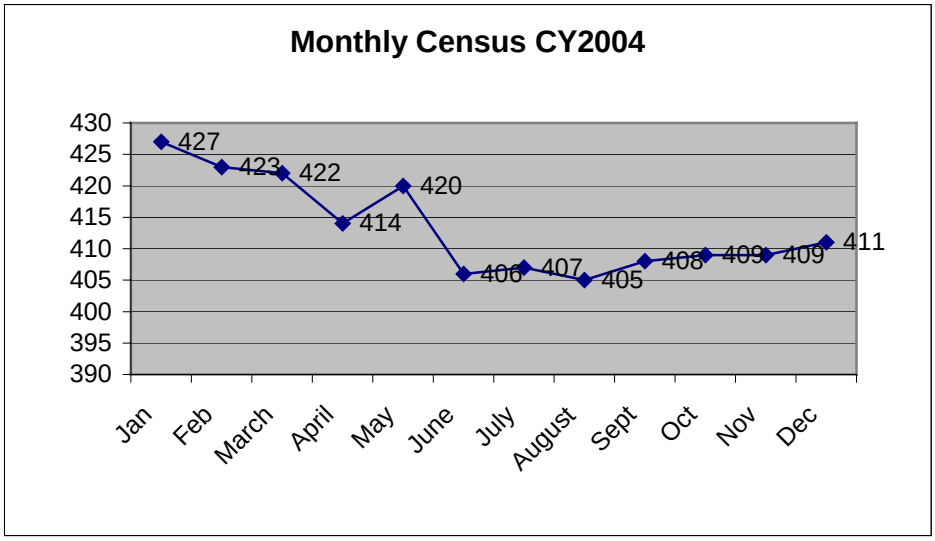
INTRODUCTION: The Office of the Inspector General (OIG) conducted a primary inspection at Eastern State Hospital in Williamsburg, Virginia during March 8-11, 2005. The inspection focused on a review of the facility through the application of 19 quality statements. These statements are grouped into 6 domains that include facility management, access to services, service provision, discharge, quality of the environment, and quality and accountability. The quality statements were formulated through interviews completed by the OIG with a number of stakeholder groups. These groups included the mental health facility directors, consumers, Department of Mental Health, Mental Retardation and Substance Abuse Services (DMHMRSAS) Central Office administrative staff, DMHMRSAS Office of Mental Health Services staff and directors of mental health services for community services boards (CSB). The quality statements and the information obtained by the OIG through observations, interviews and a review of documents are described in this report. The report is divided into sections that focus on each of the domains previously noted.

SOURCES OF INFORMATION: Interviews were conducted with 47 members of the staff including administrative, clinical and direct care staff. Interviews were also completed with 24 consumers. Documentation reviewed included, but was not limited to, 10 clinical records, selected policies and procedures, staff training curricula, the facility quality management plan, and risk management reviews. A tour of the facility was conducted. Graphs in this report were created from data provided by the facility.

BACKGROUND: ESH is a facility operated by DMHMRSAS that provides services to adults over the age of 18. The facility is the primary state hospital for nine CSBs including: Chesapeake, Colonial, Eastern Shore, Hampton-Newport News, Middle Peninsula-Northern Neck, Norfolk, Portsmouth, Western Tidewater and Virginia Beach. In addition, ESH provides services for geriatric consumers from the five CSBs in the Northern Virginia area including: Fairfax-Falls Church, Arlington, Alexandria, Loudon and Prince William.

The facility's budget for FY2004 was reported as $64,639,966. The budget for FY2005 was identified as $63,069,398. This represents a decrease in funding of $1,570,568. The cost per bed day for FY05 as of April 2005 was $462.47. The facility's operating capacity was reported to be 462 beds. At the time of the inspection, the facility had a census of 410 consumers. The census on the 1st day of each month for 2004 was as follows:



MENTAL HEALTH FACILITY QUALITY STATEMENTS

Facility Management

1. The facility has a mission statement and identified organizational values that are understood by staff.

The mission statement for Eastern State Hospital is:

> *Our mission is to assist patients and their families to effectively utilize resources that facilitate living within a community at the highest level of personal independence.*

The values of the facility as outlined in the 2005 Strategic Plan include:

> *Continuously strive to promote an environment that encourages teamwork, safety, openness, honesty, empowerment of others, cooperation and collaboration, diversity, leadership, fairness, objectivity, and improvement.*

The majority of the staff interviewed (38/47) provided responses that revealed a basic knowledge of the facility's mission. Those interviewed used phrases such as, "prepare patients for living in the community", "stabilize the patient", and "provide a safe and secure environment" to describe the mission. OIG staff was told that the facility director informs new employees during their initial orientation of the facility's mission and values. This information is reviewed again with all employees during annual retraining. Administrative staff reported that the goal of stressing the mission and values at orientation is to motivate employees to action around a shared vision for care.

The majority of staff interviewed (32/48) were able to identify three values that govern the work they do. Most of the values provided were in areas that guide how staff relate to each other and how they are expected to relate to the consumers, such as: "treatment with dignity and respect", "apply the Golden Rule", and "treat like a family member". There was little mention of the values identified in the facility's strategic plan.

2. The facility has a strategic plan.

Administrative staff reported that strategic planning within the facility occurs on a biennial basis, with an annual review of the established goals by the leadership team. Strategic plan development reportedly involves staff on all levels through unit meetings and the regular supervisory process.

The facility's strategic plan contains 15 goals, among which are:

- Protect the fundamental rights of patients and their families while providing compassionate quality care
- Create a violence and coercion free environment
- Develop a cohesive, accountable, highly trained, competent staff
- Establish a culture which promotes patient safety, recognizes the patient's rights to knowledge concerning clinical outcomes, and commits resources to the performance improvement initiatives to improve patient safety
- Identify and address high-risk conditions and deterioration of the patient's health status at the earliest possible moment

3. The mission and strategic plan have been reviewed and are linked to the recently adopted DMHMRSAS Vision Statement.

Administrative staff indicated that the facility's mission and strategic plan were not specifically reviewed following the adoption of the DMHMRSAS vision statement but that the leadership team plans to update the facility's guiding principles to emphasize recovery, consumer choice, safety, and successful clinical outcomes, which will be in alignment with the DMHMRSAS vision statement.

4. There are systems in place to monitor the effectiveness and efficiency of the facility.

The facility monitors effectiveness through various committees, performance improvement initiatives and quality assurance activities. Each professional discipline group establishes effectiveness measures. The facility director reported that the facility tracks over 100 quality indicators. The facility also tracks and monitors consumer satisfaction, the number and type of consumer complaints, the number of abuse and neglect investigations, the use of IM medications, the number of admissions/discharges and the average length of stay.

Administrative staff reported that efficiency is measured within the context of the budget. The facility monitors the cost of pharmaceuticals, fuel and overtime usage; the number of

vacancies in direct care positions; and the impact of the diversion of resources to direct services.

5. There are systems in place to assure that there is a sufficient number of qualified staff.

Data provided by the facility specified that there were 1,199.6 approved full-time employee positions, of which 1,009.27 were filled at the time of the inspection. Administrative staff reported that ESH is in the process of deleting unused and unfunded positions from their count, but this has not been completed.

Of the 428 approved human service care worker positions 344 (70%) were filled. Of the 149 approved RN-I, RN-II, and RN-III positions only 82 (55%) were filled. In addition to the 149 approved RN positions assigned to direct care, another 42 RN's are assigned to supervisory or other administrative duties.

Clinical staff positions at ESH include the following:

- 27 physicians/nurse practitioner positions filled. This includes the medical director, 17 psychiatrists, 7 medical doctors, and 2 nurse practitioners.
- 21 psychologist positions filled. Fifteen of the psychologists have a doctorate degree, and 6 have master's degrees.
- 27 social worker positions filled. There are 11 licensed clinical social workers. In addition, the social work department has 2 DSA positions to assist consumers.
- 28 activity therapist positions filled. These include 1 speech therapist, 1 physical therapist, 4 music therapists, 5 occupational therapists, 2 certified occupational therapy assistants, and 15 recreational therapists.

The direct care positions, including human service care workers and nurses, have traditionally been the positions that are the hardest to fill at this facility. It was reported that the average salary for recently hired human service care workers was $20,101 while the average salary for registered nurse positions was $48,418. It was reported that the number of competing facilities with higher pay and less required overtime in this region is one of the factors that makes recruitment and retention challenging for ESH. Staff also indicated that potential employees are reluctant to pursue careers with ESH because of the uncertainty associated with the facility's future, due to possible privatization.

Nursing administrative staff reported that several factors are reviewed to determine the appropriate number of staff for any given shift. The factors include, but are not limited to, the established minimum consumer to staff ratios, patient acuity, number of scheduled appointments and number of persons on special observation status. Administrative staff emphasized the constant struggle to meet the established staffing standards for nurses. During unit tours OIG staff observed that some units did not have an RN present on all shifts.

Nursing administration stated that current staffing patterns are designed to provide for the maximum safety of the consumers and staff while limiting use of overtime to the extent possible. The majority of direct care staff (27/32) cited the use of mandatory overtime as the primary reason for staff dissatisfaction and morale issues. Direct care staff relayed to interviewers that the short notice associated with overtime work is a source of frustration, because it is very disruptive to their lives.

Staffing patterns for registered nurses (RN), licensed practical nurses (LPN) and direct services associates (DSA) observed by the OIG during the inspection were as follows:

March 8, 2005 (Evening)

Building 2

Female Intensive Treatment Unit

1 RN (covering 2 units), 1 LPN and 3 DSAs — 9 consumers

Male Intensive Unit

1 LPN, 3 DSA s — 15 consumers

It was reported that the RN was covering the two units, and 3 of the 6 DSAs were doing overtime. Staff indicated that on average they are required to do at least 2 overtime shifts a week. Several described having difficulty working with the most challenging consumers in the intensive units after having already worked a full shift. OIG staff noted that there was very limited interaction between direct care staff and consumers. In one unit the direct care staff tended to "huddle" talking only to one another.

Building 34

Ward A

1 RN, 1 LPN and 2 DSAs — 14 consumers

Ward B

1 LPN, 3 DSA s — 20 consumers

Ward C

1 RN, 3 DSAs — 15 consumers

March 9, 2005 (Day)

Building 24

Ward B

1 RN, 1 LPN, 2 DSAs — 24 consumers

Ward C

1 RN, 3 DSAs — 19 consumers

(2 DSAs were working overtime.)

Ward D

1 RN, 3 DSAs — 14 consumers

Building 4

Ward A

1 RN, 2 LPNs, 3 DSAs — 20 consumers

Ward D

1 RN, 1 DSA — 3 consumers

March 9, 2005 (Evening)

Building 25

Ward A

1 RN, 1 LPN, 2 DSAs — 21 consumers

The RN was working the floor because of short staffing. One DSA was working overtime and 1 DSA was responsible for 1:1 coverage, so the actual remaining coverage ratio was 1: 6.5.

Ward B

1 RN, 3 DSAs — 19 consumers

The RN providing the unit coverage was the building nurse manager. Two of the 3 DSAs were working overtime.

Ward C

1 RN, 1 LPN, 2 DSAs — 22 consumers

March 10, 2005 (Day)

Building 26

Ward B

1 RN, 1 LPN, 4 DSAs — 24 consumers

One DSA was working overtime.

Ward C

1 RN, 4 DSAs — 20 consumers

One DSA was working overtime.

Ward D

1 RN, 1 LPN, 3 DSAs — 20 consumers

March 11, 2005 (Day)

Building 32

Ward A

1 RN, 3 DSAs	18 consumers

One DSA was working overtime.

Ward B

1 RN, 1 LPN, 3 DSAs	20 consumers

One DSA was working overtime.

Ward C

1 RN, 1 LPN, 3 DSAs	
1 RN, 3 DSAs	14 consumers

Building 36

Ward C

1 RN, 3 DSAs	20 consumers

Two DSAs were working overtime.

The facility assures that staff is qualified to perform their defined duties through application review, screening and conducting background and reference checks. The interview processes involve a review of the knowledge, skills and abilities the applicant would bring to the position and an assessment of their willingness to learn and develop as a professional.

Performance expectations are reviewed during the initial orientation process so that staff have a clear understanding of their duties and responsibilities. There is an extensive orientation process for direct care staff, which includes classroom instruction and on-unit training. Annual training regarding key policies and procedures is required.

Competencies are established for all direct care and clinical positions. Staff is expected to pass either written tests or be capable of demonstrating key tasks for their supervisors. Peer reviews and continuing education for licensed practitioners are on-going processes to enhance staff skills.

6. There are mechanisms for direct care staff and clinical staff to participate in decision-making and planning activities.

Administrative nursing staff reported that it is a practice of the facility to assure that there is an effective system of communication between nursing supervisory staff and the direct care employees. Building nurse managers conduct shift rounds to address any issues that arise and to provide staff with information. The administrator on duty also checks in on

staff during the evening and night shifts to assess unit functioning and to be available for staff if they have any questions or concerns. This process is in addition to regularly scheduled unit and departmental meetings.

Approximately 50% of the direct care staff interviewed (17/32) provided examples of ways they are able to participate in decision-making and planning activities. These included: involvement on various committees, nurse managers meetings, regular supervision sessions, and treatment team meetings. The remaining 50% of the staff stated that they do not feel that the facility provides an effective mechanism for line staff to participate in decision-making activities. They reported that they are informed of decisions after the fact and rarely have opportunities to participate in the process. The staff that voiced this lack of ability to actively participate were on the evening and night shifts.

7. Facility leadership has a plan for creating an environment of care that values employees, assures that treatment of consumers is consistent with organizational values, and supports recovery principles for consumers.

The facility does not have specific plans regarding methods to create an environment of care that values employees and assures that treatment of consumers is consistent with organizational values.

OIG staff was informed that the management team has been discussing ways to identify and address the perception of low staff morale across campus. A survey was conducted with staff in Building 2 to assess staff morale and objectively define both the positive and negative aspects of working within that setting. Survey results demonstrated that for the most part the respondents liked their jobs. Those surveyed perceived that morale was low for others not for them specifically. Staff identified communication, employee recognition, job security, training and environmental issues as some of the areas that needed improvement. Campus-wide employee satisfaction surveys are being considered as a follow-up to this review. Human Resources staff has also been reviewing ways to enhance staff recognition and rewards programs. Many of the direct care staff interviewed spoke of the rewards program as one of the “little things that goes a long way”.

Twenty of the 32 direct care staff interviewed (63%) reported feeling valued by their immediate supervisor and nursing administration. Staff provided the following examples of ways in which they felt valued:

- Positive feedback from supervisors and peers
- A sense of camaraderie with their peers
- Praise in newsletters or a letter from the director
- Interactions with the treatment team

Twenty-seven of the 32 direct care staff interviewed (84%) did not feel valued by the facility leadership. Those interviewed maintained they had very little contact with the facility director or other members of the leadership team.

Consumer satisfaction surveys are conducted. Results from the surveys revealed a high degree of satisfaction with the environment and the services provided. ESH staff acknowledged that interpretations from the surveys were restricted because the number of responses was very limited. Consumers informed the OIG that being able to obtain a level of functioning that allows them increased freedom is the most significant event for them during their hospitalization. Five consumers specifically wanted to be more involved in discharge planning, indicating that they would like to be present when social workers talk with community providers and family members regarding issues that directly effect them.

Access

1. There are systems in place to assure that those admitted to the facility are appropriate.

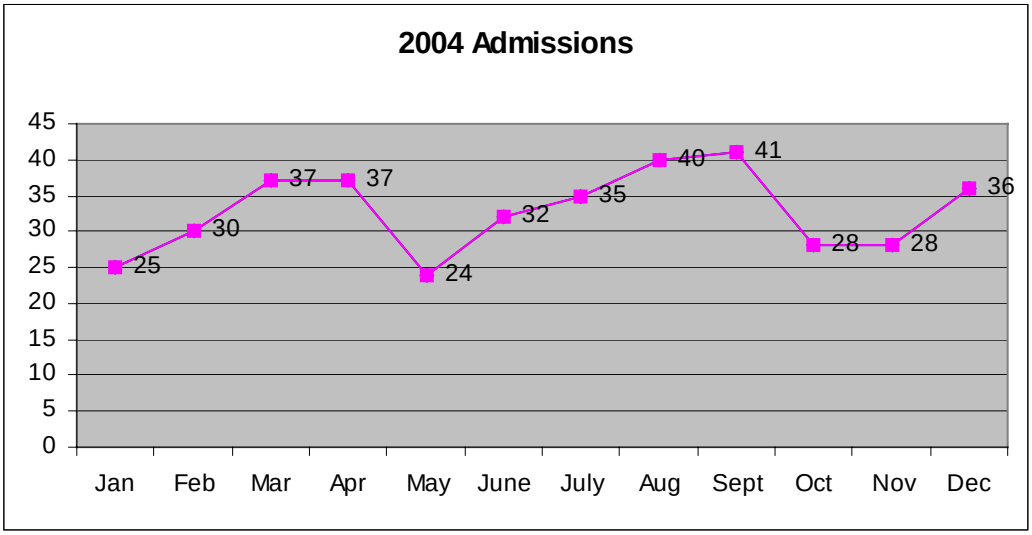
Interviews and a review of the admissions policy and clinical records demonstrated that the facility has a system for assuring appropriate admissions. ESH has been involved in a regional acute care project since November 2003. Admissions for acute care are diverted to private hospitals within the region. Members of the facility staff serve on the Regional Admissions Committee (RAC), which discusses bed utilization within the region for persons between the ages of 18 and 64. Admissions for the geriatric population served at ESH are not reviewed by the RAC.

Facility administrative staff reports that the facility admits persons whose mental status and accompanying behavior pose significant threat of harm to self or to others. These planned admissions usually are a result of a transfer from another hospital for longer-term care. The staff indicate that admissions occur when there are no community-based alternatives available to provide the level of safety and care required as determined by a prescreener from the appropriate CSB. The Code of Virginia requires that a prescreener conduct an assessment before a consideration for admission can occur.

Information collected by the OIG through interviews and a survey of community providers revealed that ESH often refuses or resists admission to consumers who are on temporary detention orders (TDO) even when a bed cannot be found in the community. Numerous reports by community providers described consumers having to stay in hospital emergency rooms up to 3 days due to lack of available bed space or the unwillingness of private hospitals and ESH to accept certain consumers. On weekends, CSBs that attempt to contact ESH for acute admissions reach only an answering machine. It is the understanding of CSBs at this point that ESH will not accept acute admissions on weekends. It was also reported that ESH is very resistant to accepting dually diagnosed individuals with both mental illness and mental retardation.

Data provided by the facility reported that there were 398 admissions to ESH during calendar year (CY) 2004. Of those admissions, 226 were male and 172 were female.

Monthly data forwarded to the OIG by the facility outlined the number of admissions per month for CY2004 as follows:



The 3 primary reasons an admission to the facility is denied include the following:

- Lack of adequate medical clearance
- Person does not meet the criteria for admission
- Lack of bed availability

ESH has an admissions unit that is staffed by a physician, a licensed nurse practitioner, a registered nurse, 2 nursing assistants, 2 admission coordinators, and 2 clerks. The OIG was informed that the profile of the population served by the adult units at the facility has changed over the past three years. It was reported that the population is younger, more clearly dually diagnosed and more treatment resistant.

2. The facility works collaboratively with CSBs to assure access to appropriate services when admissions to the facility are inappropriate or not possible due to census.

Staff reported that if it is determined that the admission is not appropriate, admissions staff assist the caller by providing information regarding possible services and placements. When the facility is over census, admissions personnel will make the arrangements for the applicant to be admitted to another state facility until a bed at ESH becomes available.

Service Provision

1. There are systems in place to assure that the patient receives those services that are linked to his/her identified barriers to discharge.

Service provision at ESH includes the integration of psychotropic medications, psychosocial rehabilitation programming, behavioral treatment and the fostering of a safe environment of care. Treatment is designed to promote symptom control and enhance the functional living skills necessary for the consumer to successfully reside in the community.

Each person admitted to the facility undergoes a series of assessments by a number of disciplines. A nurse screening of both medical and psychiatric risk factors occurs within the first half-hour of the admission process. A complete physical examination and a psychiatric evaluation are completed within the first 24-hours. The majority of assessments are to be conducted prior to the formal treatment planning session, which occurs within seven days of admission. These assessments become the basis for developing the individualized treatment plan. Interviews with clinical staff indicated that treatment objectives are established to include a focus on "barriers" to the person re-entering the community.

The OIG reviewed 10 consumer records. Each of the records contained an individualized treatment plan. There was evidence that the plan was based on the integration of the assessments completed at the time of admission. Each record contained a problem list that included a listing of the symptoms/ behaviors that were identified as the barriers to discharge. Goals and objectives with corresponding treatment strategies were noted.

ESH operates several psychosocial rehabilitation (PSR) treatment malls that are designed to provide didactic and experiential opportunities for consumers. Group activities are offered Monday through Friday with leisure activities scheduled during the evening and on weekends. Members of the OIG staff observed PSR groups for both the adult and geriatric populations. Overall, the programs were occurring as scheduled. The groups had an average of 8 consumers and 1 facilitator. One of the groups in the geriatric active treatment program had 15 consumers and only 1 facilitator. This group size was too large for consumers to receive individualized attention. Despite the facilitator's efforts to actively engage all the consumers, 2 were asleep and several others had very limited participation.

Overall, the information provided in the groups was presented in a logical and understandable manner. The facilitators worked to engage each consumer in the activity. The interactions between the facilitators and the consumers were professional, relaxed and friendly.

There was some initial confusion regarding the location of one of the groups observed in Building 14. This was a medication management group. The session was noted on the schedule as occurring in Room #1. This was clearly marked on a schedule posted by the

door to the room. However, the staff monitors present insisted that the group was to take place in Room #2 and instructed the group to go there. The group leader, who was a few minutes late, went to Room #1 to discover that there were not any consumers present. A staff member informed her that the consumers had been placed in the other room. The group leader rounded-up the consumers and moved them back to the original room. This confusion seemed unnecessary and somewhat frustrating for the consumers.

Staff members that worked in the mall and consumers informed the OIG that there was not an effective system for communicating group cancellations. They reported that consumers routinely learned of the cancellation when the facilitator failed to show up. It was also reported facilitators are often late.

Programming staff and library staff reported that consumers typically come to the library when other groups let out early, do not meet or once the treatment mall program is over. The library has a large screen television, a computer area that has internet access, listening stations for music, and a selection of reference/non-fiction/fiction books (which include large print books) and magazines. Library staff described how a visually impaired consumer often comes to the library to listen to books on tape. The library also offers basic computer classes and consumers can participate in on-line college courses.

2. There are processes in place that support evidence-based practices.

ESH has a number of processes in place that support evidence based practices. The medical staff monitors medication adherence and effectiveness. Unit psychiatrists provide the consumers and/or their LAR with the necessary information to make an informed decision regarding medication usage based upon practice guidelines. The information provided includes the medication being recommended, the dosage, the benefits and the risks. Other medication monitors and outcome measures are established such as PRN usage and the use of polypharmacy. Sixteen of the 24 consumers interviewed reported being fully informed regarding their medications. Five stated that they had been informed of their medications but not the risks and side effects associated with its usage. The remaining 3 consumers reported not being provided any information regarding medications.

Psychiatric practices such as dialectical behavioral therapy (DBT), the reduction of the use of seclusion and restraint and behavioral management plans are also examples of evidence-based practices used at ESH.

3. The facility assures that service provision is grounded in the principles of recovery, self-determination and empowerment.

None of the 32 direct care staff who were interviewed were able to identify any elements of a recovery-oriented model of care. With the exception of the PSR, there was very limited evidence of the recovery principles being utilized throughout the facility.

The administrative staff cited the active treatment program and the intent to open a transitional living community (TLC) as the program components that are most consistent with the principles of recovery, empowerment and self-determination. Staff reported that the development of the TLC is a natural extension of the work accomplished in the PSR because it enables the consumers to test their skills in a safe and secure setting. Initially, this program will serve approximately 15 consumers who are psychiatrically stable but unable to leave the facility due to non-behavioral reasons. Staff reported that during the evening and night shifts, the program will be staffed by one DSA . It was also explained that there will be times during the evening hours when consumers will be unsupervised. There will be a consultative team available to assist the consumers in the program. Nursing staff will come to the unit to administer medications, and the facility will provide the meals.

Limited access to staff in the planned TLC program will place increased responsibility on the consumers to address and manage areas of risk that would normally be handled by a group of trained staff. Patients could be placed in the position of responding to a serious injury of another patient during the absence of a trained staff member.

The OIG observed a meeting that provided interested consumers with information regarding the TLC program. About 35 consumers were in attendance. The leader explained the program and how it would operate. The group was informed that "maximum responsibility will be on the participants of the program and minimum responsibility will be on staff". It was stressed that infractions of the program rules would "not be tolerated". This co-ed program is scheduled to begin in May. It is anticipated that most of the program participants will be NGRI consumers with unescorted privileges. The consumers participating in the program will be recommended by their treatment team for consideration.

4. There are systems in place to measure the perceptions of consumers, families, direct care staff, clinical staff and administrative staff regarding the quality of the provision of care and services.

Administrative staff outlined several mechanisms for measuring the perceptions of consumers, families, and staff regarding the quality of services provided. These included satisfaction surveys for staff and patients, staff exit interviews, formal and informal meetings with families and consumers, unit and departmental meetings, and the monthly meetings with both the RAC and representatives from the CSBs.

Discharge

1. There are systems in place for effective utilization review and management.

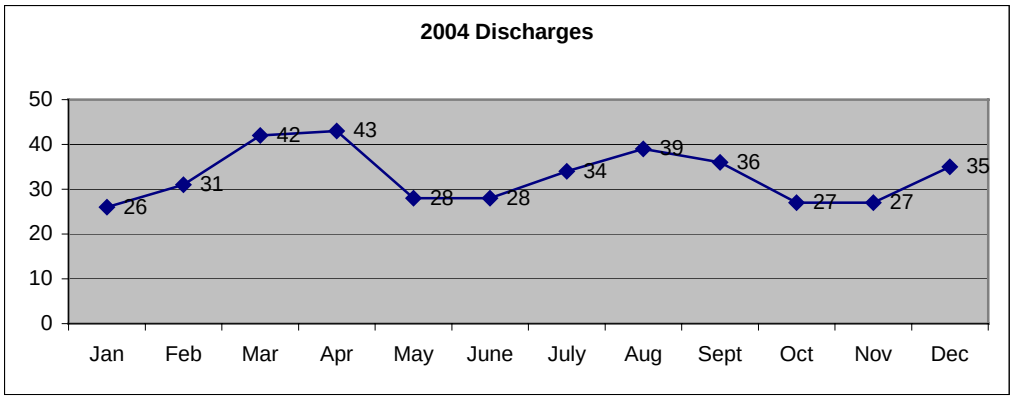
Utilization review was described by staff as a process that assures that each "patient's treatment is occurring in the appropriate setting and contains the necessary strategies for aiding the individual in achieving a higher degree of independence and functioning". The

UR coordinator is responsible for monitoring the patients' progress throughout the treatment process and determining if continued hospitalization is clinically justified. Progress toward treatment objectives is reviewed and barriers to discharge are monitored and reviewed with the treatment teams to assure that discharge occurs when it is appropriate.

ESH indicated that it works closely with community liaisons to facilitate discharge and to assure that the proper supports are identified and addressed so as to prevent re-hospitalization. Readmissions within 30 days of discharge are tracked. These cases are thoroughly reviewed to determine what additional efforts are needed to support the person in being able to be successful in the community.

Interviews with administrative staff indicated that social work staff begin the process of preparing the consumer for discharge at the time of admission, including working within the treatment team to establish a targeted date for discharge. If the discharge has not been completed by the identified targeted date, the team reviews the case to identify the areas that remain problematic and develop strategies for moving the discharge process forward.

The following chart depicts discharges on a monthly basis during calendar year 2004.



2. There are systems in place to assure that effective communication occurs between the patient, facility and community liaisons regarding discharge readiness in order to assure a smooth transition of the patient into the community and to prevent re-hospitalization.

The facility social worker works with the consumer, their LAR and the community to develop a comprehensive list of the services needed by the consumer following discharge. It is then the function of the community liaison to develop a plan for addressing these needs. Interviews revealed that weekly contact between the consumer, the social worker and the community liaison takes place in order to discuss the status of the plan and review discharge readiness. Family members (as appropriate), LAR, and community liaisons are invited to participate in regularly scheduled treatment planning meetings during which discharge readiness and plans are explored. Contact among the parties increases as the time of discharge grows closer. Crisis plans are developed for

those persons identified as high risk for re-hospitalization. Crisis plans are developed with the involvement of the consumer to determine strategies for securing supportive services within the community in the event of a situation that challenges that person's ability to safely remain in the community. Interviews revealed that effective discharge planning and established community linkages are the best mechanisms for preventing re-hospitalization.

Environment of Care

1. The physical environment is suitable to meet the individualized residential and treatment needs of the patients and is well maintained.

During the 4 day inspection, the OIG toured 19 residential units and 2 treatment malls. Overall, the residential units were clean and well maintained. Common rooms were neat and adequately furnished. Curtains are provided for both privacy and decoration. Painting techniques, pictures, faux plants and curtains are used in an effort to make this setting appear more homelike. Softening the institutional appearance of the residential units is very challenging. Exceptions to the overall observations are as follows:

> Building 24 C: The bathroom wall beside one of the toilets looked like it was stained with urine. The toilet was dirty. There was a leaky sink and toilet in that same area. Maintenance was called to check on these items and arrived while OIG staff was on the unit. The shower room had a noticeably foul odor. A consumer pointed out mildew in the shower areas.
>
> Building 25 A: This co-ed unit has several private rooms but primarily has three-person bedrooms. The OIG was informed by staff that on occasion they have to add a 4th bed to rooms due to the census on the unit. It was explained that when a 4th bed is added, facility policy requires use of a cot. Unit staff pointed out that full size beds are routinely used which is a policy violation.
>
> The OIG staff noted a toilet leaking in one bathroom on the unit. The second bathroom floor was very wet, presenting a potential safety risk for staff and/or consumers.
>
> Building 25 B: The seclusion room in this unit had a foul odor. Two of the bathrooms had a leaky toilet. One bathroom had a towel on the floor in the toilet stall that appeared to have urine on it.
>
> Building 2: The physical environment was less well decorated and appeared harsher than the other residential units on the campus.

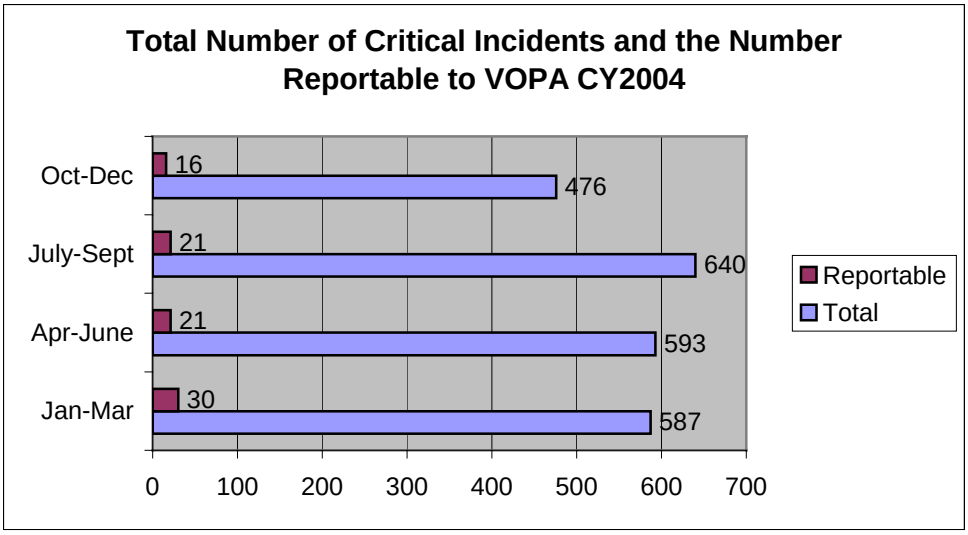
2. There are systems in place to assure that the environment of care is safe and that consumers are protected.

Safety of the consumers and staff was reported as one of the primary functions of this facility. Administrative staff stated that before effective treatment can occur, everyone involved needs to feel safe within the setting. In order to accomplish this task, the safety office is available to staff around the clock. Safety is promoted through environmental checks, staff training, and the reporting systems established for identifying and monitoring serious incidents, formal/informal complaints and allegations of abuse and neglect.

Routine rounds of all the buildings are made to assure that all equipment is in good working order and potentially hazardous situations are dealt with before a problem develops. All staff are expected to report any areas that need repair or present a risk as soon as noted. Work orders are created and completed based on the levels of risk involved, with potential life, health and safety code violations attended to immediately.

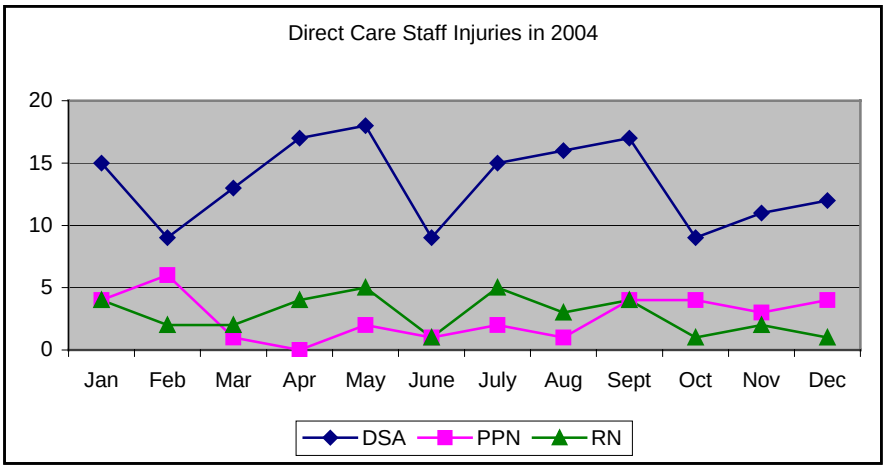
Staff is trained in key areas that have a direct impact on consumer safety such as fire safety procedures, managing challenging and difficult consumers, medication risks and benefits, human rights and the reporting of allegations of abuse and neglect. The facility has a risk management program that identifies, evaluates and seeks to reduce the risks associated with injuries, property loss and other areas of liability. Data is tracked for trends regarding a number of key indicators such as patient injuries, patient related staff injuries, allegations of abuse and neglect, formal and informal complaints, and incidents of seclusion and restraint.

According to the information provided by the facility, there were 2,296 critical incidents at the facility in CY2004. This number includes all incidents such as falls, medication errors, self-injurious behaviors of consumers, and incidents of consumers with an unauthorized absence from their unit or program. ESH defines critical incident more broadly than the criteria established for reporting to Office of Protection and Advocacy (VOPA). Of the total incidents, 88 met the criteria for reporting to VOPA. The following graph shows the total number of critical incidents and the number of reportable incidents per quarter for CY2004.



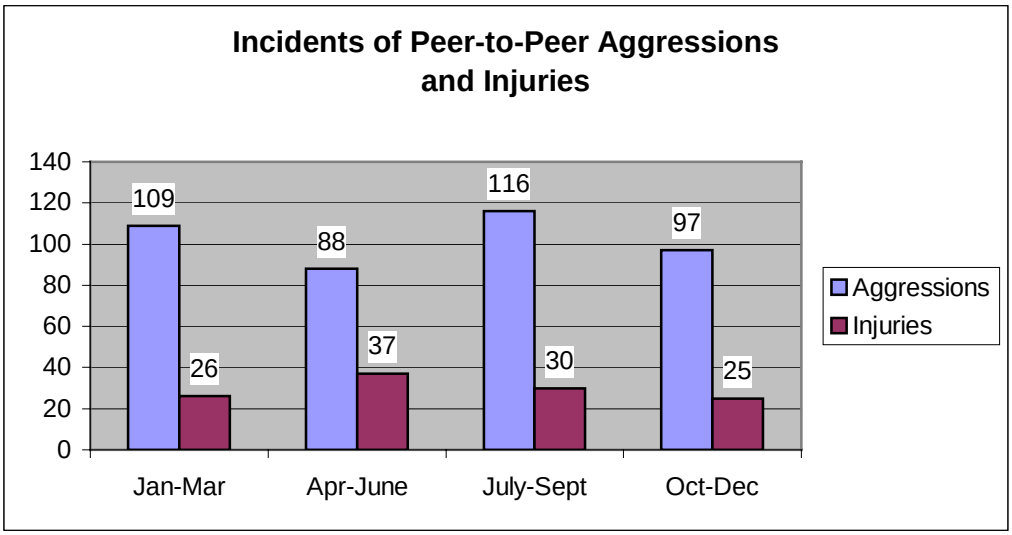
Information provided by the facility indicated that there were 123 OSHA reportable staff injuries during CY2004, of which 50 were identified as being patient related. Injuries were either the result of aggression by the consumer or occurred while staff was engaged in other consumer related activities, such as trying to prevent a consumer from falling.

Monthly data forwarded to the OIG from the facility recorded staff injuries for direct care associates, psychiatric practical nurses and registered nurses. The following graph shows the number of incidents for each classification per month during CY2004.

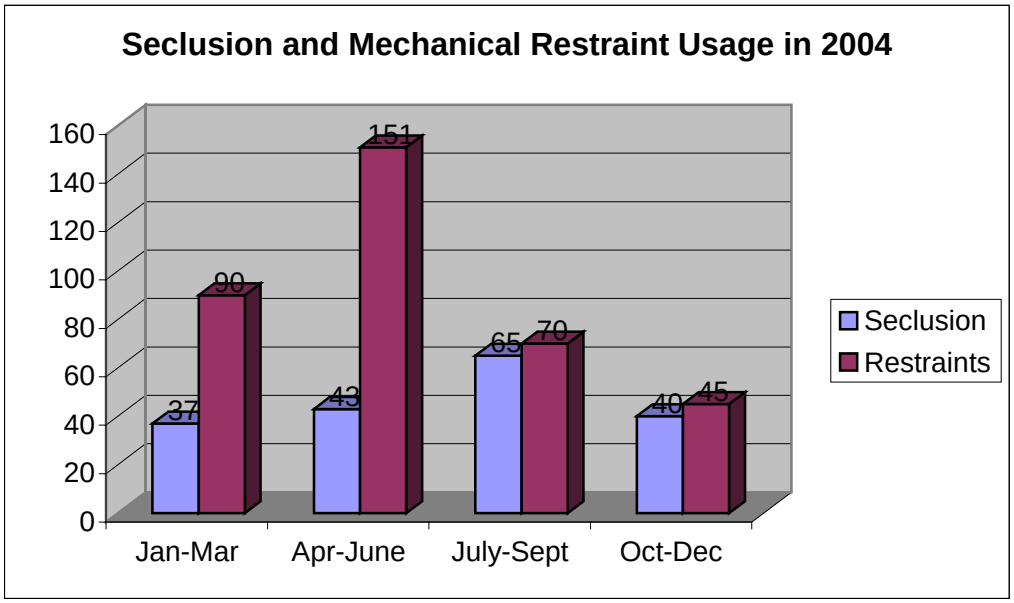


The data demonstrates that direct care associate positions are more likely to be injured than the other two classifications.

The facility recorded 410 incidents of peer-to-peer aggression during CY2004. Of these incidents, 108 resulted in an injury to one or both of the consumers involved. However, only 8 of the injuries were of severity level 2 or above. The remaining were minor and did not require medical intervention.



There were 185 incidents that resulted in the use of seclusion and 356 incidents that resulted in the use of mechanical restraints during CY2004.



All staff are provided training regarding human rights and the reporting of abuse and neglect. There were 92 allegations of abuse and neglect reported in CY2004. Of those, 8 were substantiated. Consumers filed 413 informal complaints and 40 formal complaints during CY2004.

When asked about the safety and maintenance of the environment of care, 29 of the 32 direct care staff stated that the facility did a good job in keeping the environment safe for

both staff and consumers. The remaining 3 reported that the facility was safe for the most part but wanted to qualify their statements to include safety risks when staffing patterns were allowed to reach 1 staff for 10-15 consumers. Staff informed the OIG that staff training, on-going facility safety checks by maintenance and security personnel, medications usage, and close observations are some of the mechanisms that enable the environment to be safe.

Ten of the 24 consumers (41%) interviewed reported not feeling safe within the facility. Their feelings of being unsafe were primarily linked to the behaviors of other consumers.

Quality and Accountability

1. There are systems in place to assure that the services provided from the time of admission to discharge are quality services.

ESH has a quality management program that is designed to provide quality oversight during all phases of a consumer's treatment. According to the CY2004 Quality Management Plan, the mission of Quality Management is to "provide objective, focused, monitoring of services provided by the hospital to improve clinical processes and outcomes and to establish and maintain a framework for performance improvement".

The three goals as stated in ESH's written plan include:

- Provide the focus in delivering high quality services
- Ensure that the services are provided at the right time, to the right patient, in the right place, with the expected outcomes
- Identify opportunities for improvement through measurable assessment and to ensure sustained performance through on-going monitoring and process improvement.

ESH has a Quality Improvement Council, which has the responsibility of prioritizing opportunities for performance improvement in alignment with the facility's strategic goals and objectives.

The Offices of Quality Management and Risk Management work together closely to identify and monitor a number of critical factors both within the environment of care and in service provision in order to improve quality while diminishing risks. The quality manager's duties include: overseeing the performance improvement projects within the facility, monitoring quality indicators, reporting progress through analysis of available data to the facility leadership and the Quality Council. The role of the risk manager has been expanded to address issues of liability in all areas of the facility including credentialing of contractors, issues associated with patient care and patient security, and workmen's compensation concerns.

Some examples of the facility's current performance improvement projects include: a review of atypical psychotropic medication usage, tracking weight variances for geriatric patients as a measure of nutrition, and implementation of dysphagia protocols.

2. The facility has an accurate understanding of all of the stakeholders' perceptions regarding the services provided by the facility.

Satisfaction surveys are one of the tools used by the facility in gauging the perceptions of the consumers regarding the services provided by the facility. Administrative and clinical staff reported that the facility makes every effort to assure that family members are actively involved in the treatment process whenever appropriate. It was reported that during the various interactions with family members, facility staff attempt to engage them in addressing any issues or concerns. The facility director stated that on-going interactions with community providers and representatives from the CSBs allow for open dialogue regarding services and their working relationships.

Information collected by the OIG through interviews and survey of community providers revealed that they experience the facility as very difficult to work with collaboratively. They describe a continuous pattern of resistance, delays, and the establishment of barriers by the facility leadership to effective regional planning efforts. Numerous comments by community providers indicated that the level of trust in the facility leadership is quite low.

Recommendations:

The OIG has the following recommendations regarding Eastern State Hospital as a result of this inspection. Based on the inspections of all 9 mental health hospitals and mental health institutes, a systemic review report will be issued in the near future that includes additional recommendations for all mental health facilities.

Finding #1: Several units that were inspected did not have a dedicated RN assigned to cover the shift. RN coverage for these units was provided by RNs who were assigned to other units. Of the 149 approved RN-I, RN-II and RN-III direct care positions in the facility's staffing complement, 82 (55%) were filled and 67 (45%) were not filled at the time of the inspection. In addition to the 149 approved RN positions assigned to direct care, another 42 RN's are assigned to supervisory or administrative duties. Direct care staff expressed concern that the lack of nursing staff deployed to direct care decreases facility morale and places the quality of care at risk.

Finding #2: Direct care staff report that on average they are required to work two overtime shifts per week. When this occurs, employees work two16 hour periods during the week in addition to the standard schedule on the remaining days of the week. The majority of direct care staff who were interviewed (27 of 32) stated that the use of mandatory overtime is the primary reason for staff dissatisfaction and problems with morale. Several staff reported that they have difficulty working with the most challenging consumers during the overtime shift because they are tired and not as alert. In units where there was a significant number of staff on overtime, the staff interaction with consumers was more limited than in other units.

Recommendation for Findings #1 and Finding #2: It is recommended that the facility administration, with the involvement of direct care staff and Human Resources staff from DMHMRSAS central office, (1) identify the barriers to successful recruitment and retention of staff, (2) survey other DMHMRSAS facilities to identify strategies that have been successful elsewhere and (3) develop and implement any new strategies that can be identified to resolve the staffing shortage. It is further recommended that the facility evaluate each of the 42 supervisory or administrative positions that is currently filled by an RN to determine if the duties can be carried out by an individual who is not a nurse in order to free up RN's for direct care.

DMHMRSAS Response:

Recruitment and retention is a perennial concern of the Department. Eastern State Hospital has some unique challenges to recruitment and retention including the level of competition with the private sector in the Tidewater area. While the Department is continually evaluating and adjusting recruitment and retention options, over the last year there has been a Human Resources Special Initiatives Subcommittee focused on recruitment and retention issues and concerns across the Department's facilities. Successful demonstration initiatives will be available to all facilities by December 05 and the Sub-committee will be encouraged to work with ESH to share strategies before that date. In addition, the Department Central Office Human Resources Department will be asking that facilities forward Recruitment and Retention Plans for CO review to assure maximization of successful strategy application. In specific response to the recommendations in this report, the ESH Chief Nurse Executive coordinated efforts to assess the barriers to recruitment and retention at ESH and obtained suggestions for recruitment and retention from other facilities in the Department. In addition, the positions considered to be supervisory and administrative in the report were assessed. The three areas in this recommendation are addressed below.

The ESH Assistant Chief Nurse Executive met with the direct care staff and the Chief Nurse Executive met with the ESH Human Resources Office to identify barriers to successful recruitment and retention. The following barriers were identified:

- *The necessity of using mandatory overtime*
- *Rotating shifts are needed to assure adequate coverage for all consumers.*
- *Salaries are not competitive with local private sector.*
- *Shift differentials are not competitive and do not provide an adequate incentive for working "off" shifts.*
- *The perception of the community and facility staff that the future of ESH is unsure due to the proposal from Atlantic Shores regarding privatization.*
- *Process of recruitment may have lead to delays between application and hiring*

- *The current process for position growth does not provide for career ladders.*
- *There has been a severe lack of an annual pay increases due to State budget difficulties.*
- *Childcare is very expensive, especially in relation to the salaries of the DSAs.*
- *Location – many employees do not live in Williamsburg - due to the cost of living, commuting from the surrounding communities is expensive due to the rising cost of fuel.*
- *Eastern State hospital cannot compete with private sector in either salaries and benefits or sign on bonuses.*

Eastern State Hospital conducted an informal survey of other DMHMRSAS facilities to identify strategies that have been successful elsewhere. The following were identified as successful tools in other areas of the Commonwealth:

- *The use of flexible scheduling including 10 hour or 12 hour shifts.*
- *Assignment of direct care staff to a consistent shift.*
- *The use of self-scheduling.*
- *Mandatory overtime is not needed or used.*
- *Career ladders are used for advancement and pay increases*
- *Availability of other benefits such as childcare and exercise facilities.*
- *Availability of educational assistance and the ability to schedule around course work and clinical time.*
- *Ability to provide increased pay*
- *Ability to offer increased shift differentials.*
- *Recruitment processes (broadened) – i.e. radio spot advertisement by the nurse of the month at Western State Hospital, advertisement in newspapers, etc.*

There have been recent strategies to promote recruitment and retention implemented at Eastern State Hospital:

- *The Direct Service Associates IIs have recently received shift differential (effective 7/10/05).*
- *The Parity Study done by the Chief Nurse Executives in collaboration with Central Office was completed and successful. Those Registered Nurses who were not being compensated according to their experience and abilities had their salaries adjusted accordingly.*
- *The Eastern State Hospital Chief Nurse Executive is serving on a Central Office Human Resources Committee to develop a career ladder for the state psychiatric hospital direct care staff.*
- *The Licensed Practical Nurses at ESH received an increase in pay.*
- *Voluntary overtime is being used to avoid mandatory overtime whenever possible. Employees wishing to do voluntary overtime are scheduled for the overtime first and only them is mandatory overtime initiated.*

- *ESH is currently utilizing alternative scheduling when possible to improve the scheduling flexibility.*

ESH has been asked to continue developing new strategies and to evaluate those that have been put into place to determine change in success of recruitment and retention.

The Chief Nurse Executive evaluated the Supervisory positions mentioned in this report and found that twenty-five (25) of the forty-two (42) supervisory/administrative positions cited are assigned to direct care duties and four (4) are Clinical Nurse Specialists. The other 13 positions perform administrative and supervisory duties that can only be performed by Registered Nurses.

Finding #3: Over 40% of the 24 consumers who were interviewed reported that they do not feel safe within the facility.

Recommendation: It is recommended that the facility assess its organizational culture to determine why consumers do not feel safe and what steps will be required to correct this problem. Once this assessment is complete, the facility should develop an action plan to implement the identified steps.

DMHMRSAS Response:

ESH is proposing the following method for an assessment of their organizational culture relative to consumer safety.

Consumer perceptions of personal safety will be addressed by the use of an expanded consumer satisfaction survey. In keeping with the Department's belief in consumer recovery and empowerment as critical to quality care, ESH will develop safety questions for consumers through a participatory process. The facility Risk Manager and Director of Psychology will attend consumer community meetings in each unit in order to elicit input for question development from the consumers. This is in part to assure sufficient detail in the questionnaire to be able to pin-point areas for improvement. Once the safety questions have been developed and added to the survey, the survey will be distributed to a randomly selected, numerically representative sample of consumers in each unit. Consumers who are unable to self-complete the questionnaire will be offered assistance from unit-neutral staff.

The second area of focus for the assessment process will be a survey of staff. There is a currently existing performance improvement project to improve morale in the Intensive Treatment Program at ESH. This project is based on the assumption that staff morale impacts quality of care and improvement of morale will improve patient care. This project utilized an employee morale questionnaire developed by ESH staff. Items will be added to this questionnaire that will be

developed by a focus group comprised of direct care staff representative from all units. The questionnaire will then be administered to a representative sample of staff in all units, across all shifts.

An analysis of the aggregate data will consist of a ranking of the top three areas of concern from each population (staff and consumers). These areas of concern will form the foundation on which a corrective action plan to improve overall feelings of safety at ESH will be formulated.

Finding #4: Approximately 50% of the staff that were interviewed stated that they do not feel that the facility provides an effective way for line staff to contribute their ideas and participate in decision-making activities. They reported that they are informed of decisions after the fact and rarely have opportunities to participate in the process. Most of these employees work during evening and night shifts. Of the 32 direct care staff who were interviewed by the OIG, 27 report that they do not feel valued by the facility leadership. Those who were interviewed stated that they have little or no contact with the facility director and other members of the leadership team.

Recommendation: It is recommended that the facility director engage a human resources specialist from the DMHMRSAS central office or an organizational development consultant to help assess what it is about the organizational culture and/or the facility leadership that causes staff to feel that they cannot contribute their ideas and that they are not valued. Based on the findings, the director should develop and implement a plan that will resolve these concerns.

DMHMRSAS Response:

Support has been expressed to hold semi-annual forums facilitated by the two ESH Assistant Chief Nurse Executives with Evening and Night shift employees. The Facility Director and the Medical Director plan to attend these forums as well. This is planned to encourage line staff to contribute ideas and express input to decision makers. In addition, the Facility Director and Medical Director will seek to attend the shift change meetings on a random basis to make themselves accessible and to share briefings on critical hospital issues.

In addition to the internal facility actions, Central Office Human Resources and the facility director are working together to arrange for an organizational change consultant to conduct an assessment of the ESH work culture. A plan of correction will be developed in accordance with this assessment. At this time, resources from the Darden Center are being explored.

Finding #5: Community providers find the facility difficult to work with, both with regard to consumer access and regional planning initiatives. These providers describe the facility as "resistant, inconsistent and arbitrary" in its willingness to admit even those in the most difficult crises. Concerns reported by numerous community providers include the following: ESH often refuses or resists admission to consumers who are on temporary

detention orders (TDO) even when a bed cannot be found in the community. On weekends, CSBs that attempt to contact ESH for acute admissions reach only an answering machine. It is the understanding of CSBs that ESH will not accept acute admissions on weekends. The facility is very resistant to accepting dually diagnosed individuals with both mental illness and mental retardation. For these reasons, many community providers do not consider the facility a dependable safety net for the region. Staff within the facility and numerous community providers describe a continuous pattern of resistance, delays, and the establishment of barriers by the facility leadership to effective regional planning.

> Recommendation: It is recommended that the DMHMRSAS Commissioner follow up on this finding by conducting a more in depth evaluation of the perception of the facility by community providers. Once this evaluation is complete, it is recommended that the Commissioner develop a plan with the ESH director to address the concerns that are identified.
>
> ***DMHMRSAS Response:***
>
> *The Department agrees that it is important to not only know the perception of Eastern State Hospital by the community providers, but to facilitate an enhanced working relationship between the community and facility.*
>
> *Thus, the Commissioner has requested that the Facility Director prepare and submit a plan to the Assistant Commissioner for Facilities Management which will demonstrate the development of an ESH culture of responsiveness to the regional partners in the community by September 30th, 2005. This plan will detail steps that will be taken including but not limited to: meeting with the CSB Executive Directors, their key emergency staff and others, surveying them regarding the variety of needs they are experiencing and, requesting suggestions they may have for improvement in policies and /or procedures related to admissions management. Based upon these meetings action steps will be delineated by the Facility Director with oversight of implementation by the Commissioner, and the Assistant Commissioner for Facilities Management. These steps will be available to the Inspector General as well by November 1,2005.*
>
> *An additional step that ESH has already initiated toward addressing the regional concerns with regard to the dually diagnosed was the creation of a Regional Crisis Response Team. This group first convened in March of 2005.The Team has successfully met over the past six months and has focused on identifying the needs of the dually diagnosed and the agreed upon role of the training center and the mental health facility in their region in serving the MR/MI population. The Facility Director and his leadership participate with CSB leadership in the efforts of this group in meeting this difficult to serve population.*

Finding #6: The facility psychosocial rehabilitation program (PSR) does not have an effective system in place to notify consumers when programs will be delayed in starting,

cancelled or moved to alternate space. Staff and consumers reported that group facilitators are often late arriving for their PSR sessions. When consumers arrive at their assigned PSR session, there is no indication as to whether the instructor is late, the session has been moved to alternate space, or the session has been cancelled. The result for consumers is confusion regarding where they should be or how long they should wait.

Recommendation: It is recommended that the facility establish a procedure that will assure that consumers know right away when there is a change in the PSR schedule that involves cancellation of a session, tardiness of the facilitator or change of location.

DMHMRSAS Response:

The Director of Psychosocial Rehabilitation (PSR) developed and the PSR Clinical Leadership team of ESH has adopted guidelines for all group leaders to facilitate communication regarding the status of their groups on a daily basis; including notification of cancellations, changes in locations and the expectation that group leaders are on time. Cancellations of groups and tardiness of facilitators will be monitored by the discipline supervisors. The guidelines charge the group facilitator with the responsibility of informing all participants of any changes to scheduled programs. The group facilitator, when able, will also inform the PSR Coordinator of any changes or substitutions. In the absence of the group facilitator, the PSR Coordinator will assume the responsibility for following the procedures as stated in the guidelines. A copy of the guidelines is attached as reference and would apply across other programs.

Finding: #7: Several bathrooms in residential areas were not clean. Toilets and sinks were leaking onto the floor.

Recommendation: It is recommended that (1) the facility inspect all bathrooms in residential units, identify toilets and sinks that need repair and conduct the repairs, (2) this be done regularly on a scheduled basis, and (3) that the facility establish expectations and a procedure that will assure that bathrooms are not only cleaned on a regular basis but also are cleaned on an as needed basis.

DMHMRSAS Response:

The following procedures were initiated by ESH to correct/improve the identified conditions include the following:

1) *ESH Buildings and Grounds has performed extensive water line and bathroom repairs in Building 25.*
2) *Monthly inspections by ESH Nursing Administration in Buildings 24, 25 and 26, and subsequent follow-through with Buildings & Grounds and Housekeeping.*

3) *Improvement in the quality of the Daily Nursing environmental checks on all three shifts of duty.*
4) *Housekeeping attendance and participation in the Monthly Nursing inspection process.*
5) *Reinforcement and improvement in the quality of the current bathroom-cleaning schedule.*

Future Enhancements:

The DMHMRSAS Work Order System, used by all DMHMRSAS facilities, is scheduled to be replaced in FY06 and will include enhancements in follow-up and status reporting back to the requesting unit, as well as other improvements.

Eastern State Hospital ***August 8, 2005***

Psychosocial Rehabilitation
Group Cancellations
Program Guidelines

1. *Scheduled Group Cancellations (Vacations, etc.)*
    a. *When a group facilitator is aware that he/she will not be able to hold a scheduled group in advance (i.e., vacation, day off, workshop attendance, etc.), the group co-facilitator must be made aware in order to cover the group.*
    b. *If there is no co-facilitator, the group facilitator is responsible for finding a substitute facilitator:*
        1 – an individual who has facilitated the group in the past or is facilitating a similar group
        2 – an individual from the same discipline
        3 – the group facilitator's supervisor
    c. *If unable to find a substitute, the group facilitator must make his/her supervisor aware, and the steps that were taken to secure a substitute.*
    d. *The supervisor will contact the PSR Coordinator if a substitute has not been found. The PSR Coordinator will:*
        1 – try to find a substitute facilitator
        2 – try to find another group that the participants can attend
        3 – cancel the group
    e. *If the group participants are to attend another group, or the group is cancelled, the PSR Coordinator will ensure that a sign is placed on the group room door, letting the participants know if the group is being held. The PSR Coordinator will make the supervisor aware of the disposition of the group.*
    f. *The PSR Coordinator will ensure that the group cancellation is noted on the group attendance sheet.*

2. *Unscheduled Group Cancellations (Illness, etc.)*
    a. *If a group facilitator calls in due to illness, emergency, etc., the supervisor will try to find a substitute facilitator (as outlined above) for any groups scheduled for the day.*

b. *If the supervisor is unable to secure a substitute, he/she will make the PSR Coordinator aware that the group facilitator is out.*
c. *The PSR Coordinator will follow procedures outlined above.*